Colorado's Essential Health Benefits Benchmark Plan
Response to Stakeholder Questions
Updated July 26, 2012

PROCESS & DECISION IMPLICATIONS

Who is responsible for making this decision?

What happens if Colorado doesn't make a decision about an EHB benchmark plan?

What happens after a benchmark plan is selected?

Assume the Kaiser small group plan is selected, by default or by choice. Does that mean we will all become Kaiser customers, and if so, how will the state's rural areas be served?

NEW To whom should comments be addressed?

NEW We submitted additional questions, but they haven't been answered in your most recent FAQ. Why not?

NEW Will the public comments submitted on EHBs be available on the DOI and COHBE websites? Can they be posted when received? Will the State provide information to stakeholders as to how the public comments were considered in evaluating the various plans and in its rationale for the plan ultimately selected?

STATE-MANDATED BENEFITS

Which benchmark options include state mandates?

What if Colorado adds mandated benefits through statute in 2013 or later?

What happens if Colorado selects a federal employee plan that happens to cover Colorado's mandated benefits, but is not required to by state law?

A number of plans indicate that clinical trials are not covered as a benefit. However, CRS 10-16-104(20) says that all individual and group health benefit plans must provide coverage related to clinical trials. What does this include?

BENEFIT CATEGORIES

What if one of the ten required categories in ACA isn't covered in our selected benchmark plan?

What if none of the benchmark options includes a benefit required by the ACA?

Are the benefits in the Essential Health Benefits benchmark plan a "floor" or a "ceiling"? What additional benefits can carriers add to plans after the EHB benchmark is determined?

What does it mean that HHS permits the state to "plug in" whole benefits from one of the other benchmark options? What is the HHS substitution method?

NEW Several of the plans list some form of an annual maximum dollar limit in one or more categories. Additionally, at least one plan indicates that if a service/device is determined to be rehabilitative or habilitative it will be paid regardless of the dollar limit. Are annual dollar limits allowable under the ACA, and if not, how will they be changed? Will the benefits become unlimited in 2014?

BENEFIT-SPECIFIC QUESTIONS

NEW Are nutritional counseling and developmental screenings for children currently included under early intervention services? If not, are they otherwise covered benefits?

PROCESS & DECISION IMPLICATIONS

Question: Who is responsible for making this decision?
Our goal is to select the plan that's best for Colorado. We will strive to collectively choose the option that is best for the majority of Coloradans.
Answer updated 6/29 (webinar)

Question: What happens if Colorado doesn't make a decision about an EHB benchmark plan?
If a state neglects to make a decision and submit it to HHS before October 1, 2012, HHS will impose a "default" EHB benchmark option. This default option will be the largest small group plan by enrollment. For Colorado, that is Option A, Kaiser's small group plan.
Answer updated 6/29 (webinar)

Question: What happens after a benchmark plan is selected?
After Colorado chooses a benchmark, HHS will determine if the benchmark meets ACA requirements. Then, Colorado carriers will be given details about the benchmark and asked to price that plan. In that process, carriers will be allowed some flexibility to change particular benefits, but the benefits must remain "substantially equal" to the benchmark.
Answer updated 6/29 (webinar)

Question: Assume the Kaiser small group plan is selected, by default or by choice. Does that mean we will all become Kaiser customers, and if so, how will the state's rural areas be served?
The selection of an EHB benchmark plan will not in any way impact the choice of carriers and products available to consumers, whether in rural or urban areas. The benefit design in the benchmark plan selected will simply become a blueprint for what has to be included as part of the Essential Health Benefits Package starting in 2014. All of the carriers in Colorado will use that blueprint to design their own benefit packages, and while they are allowed some variation, the value of each carrier's benefit package has to be equal to the benchmark plan.
Answer updated 7/6

Question: **To whom should comments be addressed?**
NEW Although comments need not be formally addressed, you are welcome to address them to "EHB Workgroup," which consists of staff from the Governor's Office, the Colorado Division of Insurance, and the Colorado Health Benefit Exchange.
Answer updated 7/26

Question: **We submitted additional questions along with some answered here, but they haven't been answered in your most recent FAQ. Why not?**
NEW
Some recent questions have asked in-depth questions regarding specific benefits and plans. In an effort to provide the best answers possible, we have been working with the appropriate carriers to ensure the information we provide is consistent with their own interpretation of their benefit offerings. As we arrive at the answers, we will update this FAQ.
Answer updated 7/26

Question: **Will the public comments submitted on EHBs be available on the DOI and COHBE websites? Can they be posted when received? Will the State provide information to stakeholders as to how the public comments were considered in evaluating the various plans and in its rationale for the plan ultimately selected?**
NEW
We have received a number of communications through our EHB email address at ehb@dora.state.co.us. Some of these have been questions or comments we were able to re-frame as questions, and we have made these publicly available as FAQs and responses.

As we receive comments intended to inform the decision-making process surrounding EHBs (eg, "formal" comments or position papers), we will make the documents available on the DOI's EHB website. These will be posted weekly and we will remove individual contact information, but not organization identification. We will not post email submissions that have been posed as questions and answered via FAQ.
Answer updated 7/26

STATE-MANDATED BENEFITS

Question: **Which benchmark options include state mandates?**
Benefits mandated by state law apply to Options A-F, which include the small group plans, the largest HMO, and state employee plans. They do not apply to federal employee plans, and coverage may differ in those plans.
Answer updated 6/29 (webinar)

Question: **What if Colorado adds mandated benefits through statute in 2013 or later?**
The state will have to pay for any mandates added after December 31, 2011 and incorporated into the Essential Health Benefits plan, regardless of whether a particular mandate falls within a category of benefits required by the ACA.
Answer updated 6/29 (webinar)

Question: **What happens if Colorado selects a federal employee plan that happens to cover Colorado's mandated benefits, but is not required to by state law?**
If Colorado selected a federal employee plan, state mandates would not apply. If the selected plan happened to cover benefits included in a Colorado state mandate, those benefits would be automatically incorporated into the required EHBs going forward. However, any differences between the federal employee plan and state mandates (e.g., visit limits or key definitions) would not be considered, and the state mandate would be disregarded.
Answer updated 7/6

Question: **A number of plans indicate that clinical trials are not covered as a benefit. However, CRS 10-16-104(20) says that all individual and group health benefit plans must provide coverage related to clinical trials. What does this include?**
The state mandate requires group health plans to provide routine coverage to enrollees while they are in a clinical trial. In addition, the mandate prohibits carriers from preventing a patient from accessing a clinical trial. However, the mandate does not require insurance plans to cover direct or indirect costs of a clinical trial, unless the costs would be part of the standard of care regardless of trial participation.
Answer updated 7/6

Question: **Section 1302 of the ACA requires the Secretary of the Department of Health & Human Services (HHS) to define EHBs. What will HHS's role be in determining Colorado's EHB package?**

NEW

The December 2011 HHS Bulletin directed states to select an EHB benchmark plan, which must be submitted to HHS for approval in 2012.

No additional guidance has yet been issued regarding the specific process for HHS approval of each state's EHB benchmark.

The text of the ACA provides some information regarding the key criteria the Secretary must consider in evaluating EHBs. Among additional requirements, the Secretary must ensure:

- EHBs reflect a "typical employer plan." To do this, HHS engaged the Department of Labor and the Institute of Medicine on employer plans and used this information to inform the EHB process.
- EHBs reflect an "appropriate balance" among the 10 EHB categories, "so that benefits are not unduly weighted toward any category."
- EHBs are not designed "in ways that discriminate against individuals because of their age, disability, or expected length of life."
- EHBs "take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups."

Additionally, HHS is required by the ACA to periodically review and evaluate EHBs, and make recommendations to improve upon them. In defining EHBs, and in their review, HHS must provide notice and the opportunity for public comment.

Answer updated 7/26

BENEFIT CATEGORIES

Question: What if one of the ten required categories in ACA isn't covered in our selected benchmark plan?

If our selected benchmark is missing a category of benefits required by ACA (eg, pediatric oral and vision), HHS has a substitution method that allows us to "plug in" whole benefits from one of the other benchmark options.
Answer updated 6/29 (webinar)

Question: What if none of the benchmark options includes a benefit required by the ACA?

There are very few ACA-required benefits not covered by any of the benchmark plan options. However, benefits for pediatric dental, pediatric vision, and habilitative services have not traditionally been offered through medical insurance in Colorado and nationwide, and so they may not be fully covered by Colorado's benchmark plan options.

To ensure the pediatric dental benefit is covered, HHS has indicated that a state may select from among two alternative benefit options. First, Colorado may select the pediatric dental benefit from the Federal Employees Dental and Vision Insurance Program (FEDVIP) with the highest national enrollment. Second, Colorado may select the pediatric dental benefit from the Child Health Plan Plus (CHP+), the public insurance option for children and pregnant women in Colorado.

Similarly, for pediatric vision benefits, HHS has proposed supplementing state plans with the FEDVIP pediatric vision benefit.

HHS has advanced two proposals to ensure the Essential Health Benefits include coverage for habilitative services. The first is to require parity between habilitative and rehabilitative benefits. The second is to specifically define coverage parameters for habilitative services and report that coverage to HHS in advance.
Answer updated 7/6

Question: What does it mean that HHS permits the state to "plug in" whole benefits from one of the other benchmark options? What is the HHS substitution method?

If a benefit required by the ACA is missing altogether from one of the EHB plan options, that plan does not have to be eliminated as an option for the EHB benchmark. Instead, HHS guidance gives states flexibility to supplement plans with benefits from another benchmark plan option.

For example, two of the benchmark plan options do not provide broad coverage for prescription drugs, which is one of the required categories in the ACA. As

described in FAQs released by HHS, the substitution method for a missing benefit is to essentially "borrow" benefits in the missing category from another benchmark option. So, for the plans missing prescription drug benefits, Colorado could simply substitute the missing prescription drug coverage with the prescription drug coverage of another benchmark option.

However, HHS has not formally announced a rule to govern benefit substitutions. Information to-date is only guidance that may change if HHS alters its approach.
Answer updated 7/6

Question: **Are the benefits in the Essential Health Benefits benchmark plan a "floor" or a "ceiling"? What additional benefits can carriers add to plans after the EHB benchmark is determined?**

The benefits included in the Essential Health Benefits benchmark plan will become the Essential Health Benefits Package (EHBP), which must be provided in most types of insurance sold starting in 2014. These standard benefits will allow consumers to more easily compare plans. Carriers will have some flexibility to alter the EHBP as long as their substitutions do not alter the value of the plan (changes must be "substantially equal"). Carriers may also elect to add benefits to the EHBP in the products they offer to consumers, although added benefits may mean added cost.
Answer updated 7/6

Question: **Several of the plans list some form of an annual maximum dollar limit in one or more categories. Additionally, at least one plan indicates that if a service/device is determined to be rehabilitative or habilitative it will be paid regardless of the dollar limit. Are annual dollar limits allowable under the ACA, and if not, how will they be changed? Will the benefits become unlimited in 2014?**

NEW

Under the ACA, many types of health plans – including those to required to include EHBs – will not be allowed to have annual or lifetime dollar limits on benefits classified as EHBs. However, other types of limits are allowed, including visit limits, limits on the type or amount of medical supplies, and other limits that may impact utilization of health benefits. Additionally, dollar limits are allowed on non-EHB benefits.

Although annual dollar limits are not permitted beginning in 2014, HHS has not yet released guidance on this issue.

Answer updated 7/24

BENEFIT-SPECIFIC QUESTIONS

Question: **Are nutritional counseling and developmental screenings for children currently**
NEW **included under early intervention services? If not, are they otherwise covered benefits?**

Colorado's early intervention services mandate only covers services for children who meet the criteria established by the EARLY INTERVENTION COLORADO PROGRAM administered by the Colorado Department of Human Services. This program provides special services to infants and toddlers with developmental delays and special needs. The services that must be covered under the mandate are those contained in the child's individualized family service plan (IFSP). Nutritional services would be covered for eligible children if ordered and listed on the IFSP.

Additionally, state-mandated benefits include nutritional coverage for children with inherited enzymatic disorders caused by single gene defects. This includes medical food for children with phenylketonuria (PKU).

Developmental screening is a routine part of a child's wellness visit and is separate from the early intervention services mandate. It would likely be covered as preventive care under the pediatric services EHB category.
Answer updated 7/26